

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

1370-61-006579
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1370**

AMENDED

FILED VS FEB 20 1961

DATE AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2527 N Spring
3. NAME OF DECEASED (Type or print) First EMMA Middle Last HOOD		4. DATE OF DEATH Month FEB. Day 7, Year 1961	

5. SEX Female	6. COLOR OR RACE Col.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-14-90	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY None.		11. BIRTHPLACE (City and state or country) Macon, Miss.	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Jim Johnson	13b. MOTHER'S MAIDEN NAME Mariah Williams	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Address Mrs. Viola Fair-2527 N. Spring
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Cerebral arteriosclerosis DUE TO (c) 331x		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour 1/30/61 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from **1/30/61** to **2/7/61** and last saw her/him alive on **2/7/61**.
Death occurred at **10:20 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Francis J. Cary MD	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 2/7/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-13-61	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem. Berkeley, Mo.	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR ADDRESS A.L. Beal Und. Co. -4303 Delmar	25. DATE RECD. BY LOCAL REG. FEB 10 1961	26. REGISTRAR'S SIGNATURE Boyd Smith, M.D.
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Arthur L. Holliard

Licensed Embalmer No. 4221

P. O. Address 3100 Canton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his-OWN handwriting.
If this body is not embalmed, fact should be so stated above.